Wisconsin Department of Health Services

IRIS Policy Manual

IRIS Include, Respect, I Self-Direct

1.0 Introduction to Include, Respect, I Self-Direct (IRIS)

IRIS is an authorized program under the Medicaid Home and Community-Based Services (HCBS) waiver section 1915(c) of the federal Social Security Act. Program manuals including information and policies regarding rules and regulations governing eligibility, need and amount of assistance, participant's rights and responsibilities and the services that are covered must be made public per DHS 104.01(9)(9)(a).

1.1 Background, Purpose and Philosophy

This section provides an overview of the IRIS Self-Directed Supports (SDS) program in the context of Wisconsin's long-term care system and long-term care reform implementation. This section discusses the purpose and goals of IRIS, its basis in the principles of self-determination, and a comparison to managed long-term care. This section also describes the overall structure of IRIS, the role and responsibilities of the IRIS participant and the organizational components of the program, including those entities that support participants to successfully self-direct their services.

1.1A Background

IRIS is a community-based long-term support program that began In Wisconsin on July 1, 2008. Oversight for IRIS is in the Wisconsin Department of Health Services (DHS), Division of Long Term Care (DLTC) under the authorization of the Centers for Medicaid and Medicare Services (CMS). DHS seeks input from participants and other stakeholders through a variety of advisory boards, focus groups and tribal consultations.

The Division of Long Term Care oversees the provision of several long-term support options for frail elders and people with disabilities; as well as other programs for elders and persons with disabilities. The Office of Resource Center Development (ORCD) within DLTC manages the Aging and Disability Resource Centers (ADRCs) which are the unbiased source of options counseling for people eligible for long-term care.

IRIS is available to Wisconsin residents who are Medicaid eligible, eligible for publicly funded long-term support services and who live in a county where Family Care, managed long-term care, is available. People are offered the choice of IRIS or managed long-term care when they enter the state publicly funded long term care system through the local ADRC.

IRIS was created in response to consumer demand and a directive from the federal Centers for Medicare and Medicaid Services (CMS) that individuals who are eligible for managed long-term care in Wisconsin have the opportunity to have choice relative to long-term care program enrollment. Managed long-term care includes Family Care and, where available, Family Care Partnership and Program for All-Inclusive Care for the Elderly (PACE). IRIS was designed and began to operate in July 2008 as Wisconsin's SDS Medicaid HCBS waiver program. Since November 2009, IRIS participants eligible for personal care services are also provided the option to self-direct their personal care services under Section 1915(j) of the Social Security Act through a Medicaid state plan amendment or to receive these services from an agency through their Medicaid ForwardHealth card.

People who choose to participate in IRIS have choice, control, and freedom to design their support and service plans in order to meet their functional, vocational, medical and social needs. These rights are structured within program policies and procedures to ensure compliance with the federal 1915(c) HCBS Waiver application and subsequent renewal requests filed by DHS with CMS. These HCBS waivers define the types of services and goods that are included in the IRIS program. Persons enrolled in IRIS self-manage their goods and services and may use IRIS-funded supports and services to remain in their community and avoid moving into a nursing home or other institution. Frail elders and adults with physical

or intellectual or developmental disabilities have control over the type of services they receive in allowable home and community settings through the IRIS program.

Since 2008, Wisconsin has undergone a major transformation in the way MA HCBS long-term care services are delivered statewide, moving from a system in which 72 counties managed and implemented adult HCBS waiver services to a system that provides statewide access to managed long term-care services and self-directed supports.

The state's vision for long term-care reform includes the following goals:

- Access – improve people's access to services.
- Choice – give people better choices about the goods, supports and services to meet their needs.
- Cost Effectiveness – create a cost effective long term care system for the future.
- Quality – improve the quality of the long term care system by focusing on achieving people's health and long-term care outcomes.

This statewide reform effort included the establishment of Aging and Disability Resource Centers (ADRCs) to provide options and enrollment counseling to people with long-term care needs so that they can make informed choices about their long-term care services. People who are eligible have a choice among traditional nursing home or institutional care, managed long term-care and IRIS in Wisconsin.

1.1B Purpose

The purpose of IRIS is to help participants design and implement plans for HCBS services and supports as an alternative to institutional care. IRIS facilitates participant choice, direction and control over services and supports that are purchased in accordance with a support and service plan, an individual budget range and natural supports. The goals of IRIS, as embodied in its name, refer to the following:

Include – Wisconsin frail elders, adults with physical disabilities and adults with developmental disabilities with long-term care needs who are Medicaid eligible are included in communities across Wisconsin. IRIS services help to meet a person's long-term support needs are designed by the participant or the participant's guardian to meet these needs in community settings.

Respect – Participants choose their living setting, their relationships, their work, and their participation in the community.

I Self-Direct – IRIS is a self-directed long-term care option in which the participant manages supports and services using natural supports and an individual budget range to purchase supports and services to meet their long-term care needs and outcomes within the guidelines of allowable supports and services. The participant has the flexibility to design a cost-effective and personal plan to meet long-term care needs and outcomes.

1.1C Philosophy

Self-direction means people have more choice, control, flexibility, freedom and responsibility. Within the context of IRIS, self-direction means participants decide upon the following:

- The goods, supports and services needed to help live the life he or she wants while meeting his or her long-term care outcomes.
- The amount and location goods, supports and services are provided, as well as decisions on the provider of these services.
- The use of the individual IRIS budget to meet his or her needs responsibly and cost-effectively.

- To determine the needed assistance to plan for needed goods, supports and services.

Self-direction is a tool that leads to self-determination through which participants take control of their long-term care outcomes and have more freedom to lead a meaningful life at home, at work and in their communities.

1.1D Guiding Principles

The vision for IRIS is to support participants to lead self-determined lives. Accordingly, the IRIS self-directed supports program is based on the five core principles of self-determination:

- Freedom to decide how an individual wants to live their life.
- Authority over an individual budget.
- Support to organize resources and direct services in ways that are life enhancing and meaningful to the person and that recognize the contribution that people with disabilities can make in their communities.
- Responsibility for the wise use of public dollars.
- Confirmation of the important role that people with disabilities have in being self-advocates and affecting change.

Further information about self-determination can be found at the Center for Self-Determination website at http://www.dhs.wisconsin.gov/sds/index.htm

1.2 Structure, Roles and Responsibilities

Several organizational components are in place to support the IRIS participant to successfully self-direct goods, supports and services. As Wisconsin's designated Medicaid agency, DHS retains authority for overall administration, oversight and coordination of the IRIS program. The Department contracts with agencies to assist and facilitate IRIS participants in self-direction. These agencies also provide important protections and safeguards for participants who self-direct. The contracted agency types include:

- Aging and Disability Resource Centers (ADRCs);
- IRIS Consultant Agencies (ICA); and
- IRIS Fiscal Employer Agents (FEA)

1.2A Participant

The essential leadership role of participants in planning and purchasing goods, supports and services is recognized within the IRIS program structures. The participant is the eligible individual who chooses IRIS as the program for needed publicly funded long-term care supports and services. In this manual, "participant" means:

- The participant acting independently on their own, or with the assistance of a person designated by the participant; or
- A legal representative when the representative has authority to make pertinent decisions on behalf of the participant (e.g., guardian).

The IRIS participant has three key roles in self-directing their goods, supports and services in IRIS, as well as responsibilities related to those roles.

1.2A.1 Decision-Making

Participants in the IRIS program have made a choice to self-direct all of their long-term care services and supports. This provides participants a high degree of choice and control over services and supports delivered. Participants develop their support and service plans, within their individual budget range, and direct the services and supports identified on their plans. Participants are responsible to work with their IRIS Consultant, the IRIS Consultant Agency and the IRIS Fiscal Employer Agent to implement their plans.

1.2A.2 Participant Budget Authority

Participants manage and direct an individual service budget. The person's plan defines the goods and services that will be paid to meet their long-term care needs consistent with their approved support and service plan. Participants do not set the level of funds they have available; however, they do exercise choice over how those funds are spent. Participants are accountable for the use of IRIS funds consistent with their long-term care support and service plan, established policies and procedures, and the federal waiver authority for IRIS. Payment for authorized services and supports are made through the FEA and the Third Party Claims Administrator. Participants do not receive the funds in their budget; rather payment is made through these third parties for authorized expenditures.

1.2A.3 Participant Employer Authority

Participants may hire, manage and direct their paid workers or care providers. There are two ways in which IRIS participants can carry out their employer role. One is as a common law employer, and the other is as a co-employer with an agency. A common law employer role occurs when a participant serves as the employer of record and engages in all typical employer responsibilities. These responsibilities include recruiting and hiring workers; training, scheduling and directing workers; and reviewing and approving timesheets and other documentation. If the participant chooses to be a co-employer then the responsibility of the employer tasks is shared with a qualified agency, and that agency serves as the employer of record.

1.2B Wisconsin Department of Health Services

The Wisconsin Department of Health Services is the State Medicaid Agency, and, accordingly, is responsible for providing oversight of Medicaid HCBS waiver programs in Wisconsin. The Department assures authority and responsibility for these programs, including IRIS, through administrative oversight and the issuance of policies, rules and regulations. DHS establishes policies and procedures to assure compliance with federal and state regulations governing the program. While agencies with which DHS contracts, such as the IRIS Consultant Agencies and Fiscal Employer Agencies perform key functions and activities in IRIS, each contracted agency directs policy issues and decisions to DHS. In addition, DHS ensures that Medicaid provider agreements are in place with each paid provider of self-directed services before service claims are paid.

The Department provides state oversight of ADRCs, including the quality and administrative oversight of the Long-Term Care Functional Screen which determines an individual's level of care and functional eligibility for IRIS and other adult long-term care programs.

The Department is responsible for Wisconsin's Medicaid HCBS waiver application for IRIS, as approved by CMS. Therefore DHS is required to demonstrate that the CMS assurance requirements in the HCBS waivers for IRIS are being met. The CMS assurances under the Medicaid waivers, including IRIS, are identified below, along with a description of the State Medicaid agency's demonstration of compliance with each assurance.

1.2B.1 Administrative Authority

The Department must demonstrate that it retains ultimate administrative authority and responsibility for the operation of the HCBS waiver program and provides administration of the HCBS waiver program consistent with its approved federal 1915(c) application, including oversight of the performance of waiver functions by other state, regional, local and contracted entities.

1.2B.2 Level of Care

The Department must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating and reevaluating a participant's level-of-care consistent with the care provided in a nursing home or Intermediate Care Facility for people with intellectual or developmental disabilities (ICF-IDD).

1.2B.3 Qualified Providers

The Department must demonstrate that waiver services are provided by qualified providers who meet required licensure and/or certification standards and adhere to other specified standards prior to providing waiver services.

1.2B.4 Service Plan

The Department must demonstrate that:

- Participants are afforded choice between waiver services and institutional care and among waiver services and providers;
- Service plans address participant's assessed needs and long-term care outcomes;
- Service plan development is monitored;
- Service plans are updated/revised at least annually and when warranted by changes in the participant's needs; and
- Services are delivered in accordance with the service plan.

1.2B.5 Health and Welfare

The Department must demonstrate that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

1.2B.6 Financial Accountability

The Department must demonstrate that it has a system in place for assuring financial accountability in the approved HCBS waiver.

1.2C Aging and Disability Resource Centers (ADRCs)

ADRCs are public entities that are responsible for providing accurate, unbiased information on all aspects of life related to aging or living with a disability. ADRCs are designed to be friendly, welcoming places where anyone – individuals with disabilities, concerned families or friends, or professionals working with issues related to aging or disabilities – can go for information and assistance related to long-term care.

ADRCs provide a central source of reliable and objective information about a broad range of programs and services and help individuals understand and evaluate the various options available to them. By enabling people to find resources in their communities and make informed decisions about long-term care, ADRCs can help people conserve their personal resources, maintain self-sufficiency and delay or prevent the need for potentially expensive long-term care. ADRCs serve as the single-access-point for publicly funded long-term care, including IRIS and Family Care, managed long-term care.

ADRCs perform the following key roles in Wisconsin's long-term care system:

1.2C.1 Information and Assistance

ADRCs provide information about local services and resources and assist people to find services to match their needs. ADRCs can also connect people to wellness and preventative-focused programs to help keep them healthy and independent.

1.2C.2 Benefit Counseling

ADRCs provide information about publicly funded benefits that a person may be eligible to receive, such as Medicare, Medicaid, Social Security, disability supports and low income housing, as well as other benefits. Additionally, benefit specialists advocate for people when they have issues with these benefit programs.

1.2C.3 Long-Term Care Options Counseling

ADRCs provide information about the choices that people with long-term care needs have about where to live, what kind of help they need, where to receive that care and help, and how to pay for it. In addition, ADRCs provide one-on-one consultation to help people think through the benefits and limitations of the various options given their particular situation, values, resources and preferences.

1.2C.4 Enrollment/Disenrollment Counseling

ADRCs explain the publically funded program choices that people have for long-term care, including the option of participating in IRIS, so that people have an informed decision about the program they choose. In addition to IRIS, these program choices include Family Care, and in some areas, Family Care Partnership and PACE (Program of All-Inclusive Care for the Elderly).

1.2C.5 Access to Funding for Long-Term Care

ADRCs are the entry way to the publicly funded long-term care system. They administer the automated Long-Term Care Functional Screen to determine if people with long-term care needs are functionally eligible for public funding of long-term care. ADRCs also coordinate with Income Maintenance agencies to assist participants with the Medicaid financial eligibility process.

Further information about ADRCs, their role and responsibilities can be found at the DHS website:
http://www.dhs.wisconsin.gov/LTCare/adrc/index.htm

A directory of ADRCs can be found at:
http://www.dhs.wisconsin.gov/LTCare/adrc/customer/adrccontactlist.pdf

1.2D Income Maintenance (IM)

Income Maintenance, formerly known as Economic Support, is a regional consortium of counties, a subunit of a tribal government, or a state-operated entity, responsible for determining financial eligibility for publicly funded programs, including IRIS, and other public benefits. Income Maintenance staff determine financial eligibility using the state's Client Assistance for Reemployment and Economic Support (CARES) system. All Medicaid cost share and spend down calculations are made by the IM Office.

A directory of IM agencies can be found at:
http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm

1.2E IRIS Consultant Agencies (ICA)

The federal Medicaid waiver authority for IRIS requires that information and assistance be made available to facilitate self-direction. The ICAs, under contract with DHS, provide flexible and specialized supports that are responsive to a participant's needs and preferences.

The IRIS Consultant Agencies' roles and responsibilities focus on several key areas to support the IRIS participant in self-direction as follows:

1.2E.1 Enrollment in IRIS and Continued Eligibility

The ICAs:

- Provide initial orientation for a person who has chosen IRIS for long-term care, including assisting the person in selecting a consultant who will work in partnership with the participant.
- Provide comprehensive and detailed IRIS program orientation and skills training to participants related to self-direction, support and service plan development and individual budget management.
- Provide information and training to participants regarding individual budget management and the participant's obligations for financial accountability and eligibility in the program.
- Provide information and training to participants regarding the roles and responsibilities of being an employer.
- Establish a participant's IRIS start date and coordinates and communicates this start date with the ADRC and IM.
- Provide information to participants on the participant's responsibilities related to cost share or spend down obligations as calculated by IM.
- Conduct functional screens for IRIS participants annually to ensure that continued functional eligibility is maintained, and when a change in participant condition warrants a new functional screen.
- Interact with the Fiscal Employer Agencies, the ADRCs and DHS as needed surrounding IRIS continuing eligibility issues.
- Review budget status and expenditure reports with the participant.

1.2E.2 IRIS Consultant Network

- Develops and maintains a network of consultants.
- Provides general and specialized support and information to IRIS consultants regarding such matters as housing, employment, youth transition planning, behavioral management and relocation assistance.
- IRIS consultants are trained and responsible to:
    - Assist participants in understanding IRIS.
    - Serve as an ongoing source of collaboration and support to participants in self-direction.
    - Provide a level and frequency of consultant support that is responsive to a participant's changing strengths, needs and preferences.
    - Assist a participant in the development and ongoing implementation of their support and service plan and use of the budget, including the identification of informal or natural supports.
    - Assist participants, as needed, in the identification of qualified service providers and helps to ensure that service providers receive adequate training.
    - Develop and submit requests for additional funding to meet exceptional, changing and/or one-time needs to DHS.

- Administer the review and approval process for support and service plans for IRIS participants, including changes or additions to plans as appropriate.
- Review budget updates and exceptional expense requests and submits completed documentation to DHS for review and approval.
- Help assure program quality through various quality management activities that are carried out in partnership with the participant and DHS. These activities involve, but are not limited to: personal experience outcomes, provider qualifications, participant emergency and back-up plans, critical incident reporting, and service plan and budget monitoring.
- Act as the primary contact for program participants.
- Assist participants to coordinate their IRIS-Self Directed Personal Care services.

1.2F IRIS Fiscal Employer Agent (FEA)

The federal Medicaid waiver authority for IRIS does not permit payments for services to be made directly to IRIS participants. Instead, participants have individual budget authority to decide upon the funded supports and services. The payments are made through the IRIS FEA or the Third Party Claims Administrator (TPA). The FEA or TPA, under contract with DHS, performs IRIS related financial transactions on the participant's behalf, such as paying for goods and services, processing payroll for the participant's hired workers and processing agency provider invoices.

The FEA supports the IRIS participant in carrying out their budget and purchasing role and employer role as follows:

1.2F.1 Support for Participant Budget and Purchasing

- Conduct criminal and caregiver background checks for selected workers initially and at least every four years thereafter and interacts with the participant, the ICA and DHS on these results as needed.
- Assure completion of required documentation for newly hired workers, such as verifying workers' citizenship or legal alien status and completing required forms.
- Verify that workers and other providers selected by the participant meet the provider qualifications for the services that they claim for payment.
- Ensure that MA provider agreements are signed and maintained on behalf of DHS consistent with federal Medicaid HCBS waiver requirements.
- Receive and process participant authorized worker timesheets consistent with the participant's support and service plan.
- Secure coverage and pays workers' compensation insurance premiums and employee benefits for participant hired workers as requested by the participant.
- Operate a payroll service that completes bi-monthly payroll for the participant hired workers, including the withholding of federal and state taxes from wages, and the filing and payment of federal and state employment taxes and insurance premiums.
- Process any garnishments or levies on employee wages as ordered by a court.
- Deposit electronically, or mail, worker payroll checks to the participant to give to their workers or provide checks directly to the participant's workers based on the preference and direction of the participant, or deposits paychecks onto a prepaid debit card.
- Receive and account for all required IRIS participant Medicaid cost share or spend-down payments, when applicable, to maintain an individual's Medicaid and IRIS eligibility.

- Process and pay participant authorized vendor invoices for goods and services submitted by the participant and consistent with the participant's support and service plan.

1.2G IRIS Self-Directed Personal Care Agency (IRIS SDPC)

Participants who are eligible for personal care may obtain their personal care assistance from either a certified Medicaid Personal Care Agency (MAPC), or through the IRIS-SDPC option. The Department contracts with an agency to administer the program. Agency nurses perform clinical assessments and obtain the needed authorizations that enable the participant to employ his or her own workers. The wages of participant employed, personal care workers are paid through the IRIS Fiscal Employer Agent.

2.0 Eligibility

Per 42 CFR 442.302(b-c), all participants must meet and continue to maintain functional, financial and nonfinancial eligibility requirements.

Eligibility requirements are based on several factors. To be eligible, the IRIS applicant must meet the following criteria:

1. Must be at least 18 years of age;
2. Meet applicable requirements for Wisconsin residency and live in a county where the IRIS and Family Care programs are available;
3. Meet the definition of an eligible population (i.e., target group);
4. Meet functional eligibility including NH or ICF-IDD level of care assignment;
5. Meet the financial eligibility criteria for Medicaid;
6. Meet the non-financial eligibility criteria for Medicaid;
7. Reside in a program-eligible setting or living arrangement, and
8. Have a need for long term care supports and services.

2.1 Functional Eligibility

This section describes the functional eligibility requirements for the IRIS HCBS Waiver Program. IRIS is a federally approved HCBS waiver. Participants must meet the definition of an eligible target population and also have a level of care assignment that would allow admission to an NH or an ICF-IDD. The long term care eligibility condition must be expected to last more than 12 months. Eligible target populations include adults with a developmental disability (DD), adults with a physical disability (PD) and frail elders (FE). All participants must also have a Nursing Home level of care assignment.

2.1A Wisconsin Adult Long Term Care Functional Screen (LTC FS)

Functional eligibility for the IRIS program is established when the applicant meets an eligible level of care. To determine the level of care, a qualified screener with the ADRC conducts a face-to-face interview with the applicant and completes the Wisconsin LTC FS. The functional screen process gathers relevant information from the person, their family, formal and informal caregivers, health care professionals and other relevant sources, as necessary. Upon completion of the screening process, the collected information is entered into the LTC FS, the Department's automated eligibility determination system, and the functional screen logic determines whether the person's needs meet a level of care.

2.1A.1 Developmental Disability (DD)

Under federal rules (Public Law 106–402) a developmental disability (dd) means a severe and chronic disability of an individual which:

a. Is attributable to a mental or physical impairment or a combination of mental and physical impairments;
b. Is manifested before age 22;
c. Is likely to continue indefinitely;
d. Results in a substantial functional limitation in **three or more** of the following areas of major life activity:
    i. Self-Care;
    ii. Receptive or expressive language;
    iii. Learning;
    iv. Mobility;
    v. Self-direction;
    vi. Capacity for independent living;
    vii. Economic self-sufficiency; **and**
e. Reflects the person's need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of a lifelong or extended duration and are individually planned and coordinated.

The Wisconsin definition of DD is broader than the federal definition. However if a person meets only the state's definition of DD, the person will not meet the federal dd definition.

2.1A.2 Physical Disability (PD)

Wisconsin statutes (s. 15.197 (4)(a)2), define physical disability as a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly impairs at least one major life activity.

Major life activity means any of the following:

a. Self-care;
b. Performance of manual tasks unrelated to gainful employment;
c. Walking;
d. Receptive and expressive language;
e. Breathing;
f. Working;
g. Participating in educational programs;
h. Mobility, other than walking; and
i. Capacity for independent living.

2.1A.3 Frail Elder (FE)

Wisconsin Administrative Code (DHS 10.13 (25m), defines the term frail elder as an individual aged 65 years or older who has a physical disability, or an irreversible dementia, that restricts the individual's ability to perform normal daily tasks or that threatens the capacity of the individual to live independently.

A qualifying functional screen result means that the person has a need for services and supports that is equivalent to the threshold level of care necessary for nursing home or ICF-IDD admission. Identified issues may include a need for assistance with activities of daily living (e.g., bathing, dressing, eating and mobility) and/or instrumental activities of daily living (e.g., meal preparation, medication and money management). Screen findings may also indicate a need for assistance with health related services that can include: nursing assessment, interventions related to behaviors and skilled therapies.

Medical diagnoses are not considered individually in determining functional eligibility. Rather, the LTC FS assesses the impact of the medical diagnosis on the participant's ability to complete both the activities of daily living (ADLs) and instrumental activities of daily living (IADLS). For example, a participant's LTC FS would not be affected due to the documentation of seizures in the diagnoses table. However, the participant's seizures may affect his or her ability to complete ADLs and IADLs and this would be represented in these needs in the LTC FS. Therefore, the impact of the seizure diagnosis is addressed in determining long term care needs.

2.1B Level of Care

In addition to having long term care needs documented in the LTC FS, all people enrolled in the IRIS Program are required to have one of two levels of care. For elders and persons with a PD this is a Nursing Home Level of Care. For individuals with a DD the level of care assignment must be ICF-IDD. In each of these situations the level of care verifies that the person meets the functional eligibility requirements to live in either a Nursing Home or an ICF-IDD.

2.2 Financial Eligibility

This section describes the financial eligibility requirements for the IRIS Medicaid HCBS Waiver Program. Applicants must meet financial eligibility requirements for Medicaid to participate in the program. In IRIS, as in Wisconsin's other MA HCBS waiver programs, the Medicaid eligibility limits are somewhat broader than those in the traditional Medicaid fee-for-service programs. This is because eligibility for the waiver programs is similar to eligibility for institutional Medicaid. If Medicaid financial eligibility is not present at application, then the individual is not eligible for the IRIS program. For current limits and restrictions, please reference the Medicaid Eligibility Handbook http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm. Financial eligibility is determined by the local IM Agency.

2.2A Assets

Asset eligibility for the IRIS program is comparable to the Wisconsin Elderly Blind and Disabled (EBD) Medicaid program. Asset eligibility determinations for SSI, SSI-E, 1619(a) and 1619(b) program participants are made by the Social Security Administration. The IM Agency determines asset eligibility for most other applicants. Generally, IRIS program applicants who are single may have no more than $2,000 in countable assets. Exceptions to the $2,000 limit include those persons enrolled in the Medicaid Purchase Plan (MAPP) or those participating in the BadgerCare Plus program.

Examples of countable assets may include: cash on hand, money in savings and checking accounts and other "liquid" assets. Other countable assets may include non-home property, stocks and bonds and the 'cash value' of certain life insurance policies.

Some assets are exempt; these may include the home of the participant, a vehicle owned and used by the participant and burial or funeral trusts up to a certain value. There are several categories of exempt, unavailable and countable assets in Medicaid, and the eligibility rules are complex. For questions as to which resources may be counted and which may be exempt, IRIS applicants should consult with an ADRC benefit specialist or the IM agency, or reference Section 16 of the Medicaid Eligibility Handbook.

For applicants who are married, spousal impoverishment asset protections available to the community spouse of an institutionalized person also apply to IRIS applicants/participants. Spousal impoverishment is addressed in more detail in Section 2.2C below. See also Section 18 of the Medicaid Eligibility Handbook.

2.2B Income

Income eligibility for IRIS program participation is based on state and federal Medicaid criteria and Wisconsin's federally approved Medicaid HCBS waivers. These rules are comparable to institutional Medicaid; therefore income eligibility limits for all Medicaid HCBS waiver programs are broader than other types of Medicaid. As a result, many people residing in the community who would be otherwise ineligible for Medicaid may become financially eligible via Medicaid HCBS waiver programs. Financial eligibility may occur in one of three income-based categories referred to as Group A, Group B and Group C. Financial eligibility criteria specific to each of these groups is described below.

Participants meeting the eligibility requirements who are employed, or seeking employment, are eligible for the IRIS program if their earnings are within the Medicaid allowable monthly earnings limits (see section 15.5 of the Medicaid Eligibility Handbook). If an employment outcome is established in a person's plan, then the participant can request Work Incentive Benefits Counseling as a waiver allowable service. The benefits specialist will assist the participant in determining the impact of work and earnings on the participant's financial eligibility.

2.2B.1 Group A

Financial eligibility Group A includes those persons who are Medicaid or Badger Care eligible at the time of application in a full benefit program. Group A also includes:

- Supplemental Security Income (SSI) and Supplemental Security Income Exceptional Expense (SSI-E) recipients,
- 1619 (a or b) SSI work incentive program recipients,
- 503 recipients,
- Widow/widowers,
- Disabled Adult Children (DAC),
- Medicaid – Medically Needy recipients with a met deductible,
- Katie Beckett Medicaid participants,
- BadgerCare Plus – Standard Plan participants (Income at or below 200% of the Federal Poverty Level (FPL),
- Wisconsin Medicaid Purchase Plan (MAPP) enrollees,
- Foster Care Medicaid participants, and
- Special Needs/Subsidized Adoption Medicaid participants.

Persons eligible as Group A have no cost share obligation, although MAPP and BadgerCare Plus participants may pay a premium for those programs based on income. Other persons who may be eligible in Group A include low income persons receiving Elderly, Blind or Disabled (EBD) Medicaid who are age 65 years or older.

Not included in Group A are persons who are enrolled in the Wisconsin SeniorCare program and other partial benefit Medicaid programs including the BadgerCare Plus – Benchmark Plan. Other partial benefit programs not included in Group A include Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB) and SLMB+, Qualified Disabled and Working Individuals (QDWI); Tuberculosis-related Medicaid, Presumptive Eligible Pregnant women and those receiving emergency services for non-qualifying aliens. While not financially eligible in Group A, some partial benefit Medicaid recipients may be financially eligible in Group B or C. Please consult with the IM Agency or the Medicaid Eligibility Handbook (Section 25, 32 and 33) for more information about partial benefit Medicaid programs.

For all Group A financially eligible persons choosing to participate in IRIS, the ADRC verifies Medicaid eligibility and initiates a referral to the ICA to complete the IRIS enrollment and service planning process.

2.2B.2 Group B

Financial eligibility Group B includes those persons whose countable monthly income is equal to or less than 300% of the SSI Federal Benefit rate. This amount is adjusted annually and can be obtained from Section 39 of the Medicaid Eligibility Handbook. All Group B Medicaid financially eligibility determinations are processed by the IM agency using the state's computerized CARES system.

IRIS applicants in financial eligibility Group B are allowed certain deductions from their income in the eligibility and post-eligibility determination processes. When applicable, married Group B applicants may also have spousal impoverishment protections applied.
At the initial application stage, the ADRC staff assists the Group B applicant to gather supporting documentation to verify countable deductions and exemptions from income. Examples of these include monthly medical and remedial expenses, special exempt income, applicable housing costs, and other deductible expenses. ADRC staff then provides these figures to the IM agency and assist the applicant to set up an appointment with IM staff to complete the Medicaid application.

At the time of application, the IM staff verifies the information provided and enters the income, allowable expenses, applicable disregards and allowances into the CARES system for the Group B financial eligibility and cost sharing determination. Please consult with the IM Agency or the Medicaid Eligibility Handbook for more information about Group B financial eligibility.

2.2B.2.1 Medical/Remedial Expenses

Medical/remedial expenses for Group B are those recurring, monthly costs that directly relate to the person's care needs and/or costs incurred while treating or preventing or minimizing the effects of illness, injury or other impairments to the individual's physical or mental health. Allowable medical/remedial expenses include items and services that are purchased by the applicant and that are not covered by the Medicaid state plan, by Medicare, or by a private health plan and are not paid for by IRIS or by another funding source. Items or services that can be purchased under the IRIS program should not be counted as a medical or remedial expense.

a. Medical Expenses

Medical expenses include costs incurred for items or services that are prescribed or recommended by a medical practitioner licensed to practice in Wisconsin or another state. Medical expenses also include costs incurred for items or services that are prescribed or recommended by a practitioner of the healing arts who engages in the practice of their profession within the scope of their license, permit or certification in the State of Wisconsin or another state.

Countable medical expenses may include over-the-counter remedies, medical or therapeutic supplies, as well as deductibles or co-payments for Medicaid, Medicare or another health plan. Allowable expenses may also include bills for durable medical equipment, items or services that are not covered by Medicaid or by another payer or bills for such medical costs that were incurred prior to Medicaid eligibility and which are being paid by the applicant.

Note: Certain medical bills cannot be counted as medical or remedial expenses. These include:

- Medical bills which remain unpaid, but were used previously to meet a Medicaid deductible;
- Bills which were incurred for institutional care provided during a previous Medicaid divestment penalty period;
- Bills that represent a patient liability amount/cost share incurred during some previous period of institutionalization or an unpaid Medicaid HCBS Waiver cost share obligation;
- Medical bills which will be paid by a legally liable third party (e.g. private health insurance, Medicare or Medicaid); and
- Bills which were previously allowed as a medical/remedial expense and counted to reduce a waiver cost share or used to reduce a nursing home patient liability obligation.

b. Remedial Expenses

Remedial expenses for Group B include services or items that are identified in the individual's assessment, deemed necessary to assist the person in community living and may be included on the support and service plan, but will not be covered by Medicaid, the IRIS program or another payer.

Note: Room and board costs may not be counted as a medical or remedial expense.

When determining the person's monthly total amount of medical/remedial expenses for Group B financial eligibility, only those allowable expenses that are both incurred and paid by the applicant can be counted. Items or services that were bought for someone else (a spouse, child, etc.) or paid for by another person, or by the IRIS program, the Medicaid card, a private health plan or any other program are not counted. This differs from expenses allowed for Group C financial eligibility calculations which are discussed below. For additional information and a listing of examples of common medical and remedial expenses, see the Medicaid Eligibility Handbook, Section 15.7.3.

2.2B.2.2 Medicaid Cost Sharing

After the allowances and expenses described above are deducted, if there is any remaining income available, then the applicant will have a cost share obligation. The cost share is the amount of the participant's income that must be paid each month toward the cost of planned supports and services. Cost share payments are collected monthly and monitored by the IRIS Fiscal Employer Agent (FEA). The payment of the cost share is required for continued program eligibility. Failure to meet the cost share obligation may result in disenrollment from the IRIS Program (see 2.0, Enrollment) and a referral to the Department of Revenue for collection of delinquent cost share. No cost share payment is required when an admission to a hospital, nursing home or ICF-IDD results in a stay long enough for the participant to incur a patient liability cost.

When the application is processed, and a cost share obligation is determined, the IM staff "pends" the application in CARES and provides the IRIS applicant and the ADRC with the cost share information. Using the information provided by IM, the ADRC staff and the IRIS applicant discuss eligibility and cost sharing requirements. If the applicant decides to proceed with enrollment, then the ADRC staff notifies IM of the decision and makes the referral to the ICA to begin the IRIS program enrollment and service planning process.

2.2B.2.2.1 IRIS Consultant Agency and IRIS Consultant Role in Cost Shares

The ICA documents the participants cost share obligation as determined by IM at the time of referral. If medical/remedial expenses have been identified to offset the cost share obligation, then the IRIS consultant monitors that the participant continues to incur these expenses on an ongoing basis. The ICA reports any changes to medical or remedial expense payments to the IM. The ICA is informed of the monthly status of cost share payment and the IRIS consultants discuss any concerns with the participant at the next consultant visit with the participant. Based on cost share history reports from the FEA, if a participant fails to pay more than two monthly cost share payments when due, then the ICA offers the participant the chance to repay the arrears through a repayment plan. If repayment plan proves unsuccessful, then DHS provides the ICA approval to initiate a program disenrollment for failure to pay the required Cost Share. Once approved by DHS, the ICA refers the person to IM to initiate the Medicaid disenrollment process. The IM office sends a formal disenrollment notice including the last date of Medicaid eligibility to the participant and informs the participant of his or her right to appeal. When the process is completed, the participant's Medicaid eligibility is ended. People who leave the IRIS program with an outstanding balance are referred to DHS collections to recoup the required Cost Share obligation.

2.2B.2.2.2 Fiscal Employer Agent (FEA) Role in Cost Shares

The FEA receives the participant's cost share payments and documents the payment. Information on cost share payment history is sent monthly to the participant. The FEA forwards a record of payment history to the ICA monthly. The FEA deposits all cost share funds received and this income offsets IRIS program funded service costs.

2.2B.3 Group C

Group C financial eligibility includes persons whose countable monthly income exceeds 300% of the current federal SSI benefit rate. This amount is adjusted annually. For current income levels, refer to Section 39.4 of the Medicaid Eligibility Handbook.

The IRIS applicant/participant meets Group C financial eligibility when his or her net monthly income, after deductions for allowable expenses, is equal to, or less than, the Medicaid Medically Needy income standard. Eligibility is determined in two steps; first by calculating expenses and applying these to the standard. If that standard is met, then a second calculation determines the actual monthly spenddown amount (see also Section 28.8 of the Medicaid Eligibility Handbook).

To remain eligible, the Group C participant must incur and be financially responsible for sufficient countable expenses to meet the spend-down amount every month. At the time of the application the ADRC staff assists the IRIS applicant to gather Group C medical/remedial expense information and other documentation of allowable expenses and helps connect the applicant to the IM agency for eligibility processing. When calculating eligibility, the IM worker enters the gross income, and applicable income disregards and the Group C medical/remedial expense information is entered into the CARES system. Please consult with the IM Agency or the Medicaid Eligibility Handbook for more information about Group C financial eligibility. Additional deductions entered may include any special exempt income, countable health insurance premiums, excess self-employment expense, and Medicaid card coverable expenses.

2.2B.3.1 Medical/Remedial Expenses

Medical/remedial expenses for Group C are those recurring, monthly costs that directly relate to the person's care needs and/or costs incurred while treating or preventing or minimizing the effects of illness, injury or other impairments to the individual's physical or mental health. Allowable medical/remedial expenses include items and services that are purchased by the applicant and that are not covered by the Medicaid state plan, by Medicare, or by a private health plan and are not paid for by IRIS or by another funding source. Items or services that can be purchased under the IRIS program are not to be counted as a medical or remedial expense.

Allowable medical/remedial expenses for Group C include out-of-pocket medical/remedial expenses, as defined in Group B above, and may also include the costs of any planned services that would otherwise be funded by the IRIS program. The expanded medical remedial expenses are counted in Group C because they represent costs that the participant will be responsible for each month, as s/he spends down to meet income eligibility.

2.2B.3.2 Medicaid State Plan (Medicaid ForwardHealth Card) Covered Services

In addition, Group C allowable expenses include expected Medicaid State Plan (Medicaid card) covered services. These include any of the participant's monthly medical expenses covered by the Medicaid state plan that are paid by the participant.

2.2B.3.3 Spend-down and Cost Share

After receipt of the list of medical/remedial expenses, service plan costs and Medicaid state plan costs, the IM worker calculates the applicant's financial eligibility and his/her monthly spend-down amount using CARES.

If spousal impoverishment rules apply, then an additional step to determine the participant income allocation and cost share, if any, is completed by the IM using the Spousal Impoverishment Income Allocation Worksheet.
The worksheet calculation determines any income amount to be allocated to the community spouse and/or dependent family members (Section A and B.) In Section C of the worksheet the IM enters the personal maintenance allowance, the income allocation amount(s), any exempt income, allowable medical remedial expenses and health insurance premiums to determine any subsequent cost share obligation.

After completing the calculation, the IM staff provides information on the Group C determination to the IRIS applicant and the ADRC enrollment staff. As in Group B, the application status will be maintained in CARES as "pending" until the IM agency receives confirmation from the ICA that the applicant has chosen to proceed to enrollment. If enrollment goes forward, then the application is activated and CARES generates a notice to the participant of the calculated spend-down amount and any cost share obligation, as applicable.

2.2B.3.3.1 ICA Monitoring

The ICA documents the participants spend down obligation as determined by IM at the time of referral. The ICA is informed of the monthly status of spend down payments by the FEA and the IRIS consultants discuss any concerns with the participant at the next consultant visit with the participant. Based on reports from the FEA if a participant fails to pay his/her monthly spend-down obligation, then the ICA obtains DHS approval to initiate a program requested disenrollment. Once approved by DHS, the ICA refers the person to IM to initiate the Medicaid disenrollment process. The IM office sends formal disenrollment notice including the last date of Medicaid eligibility to the participant and informs the participant of the right to appeal. When the process is completed the participant's Medicaid eligibility ends.

2.2B.3.3.2 FEA Monitoring

The FEA receives participant spend down payments and documents the payment. Information on spend-down payment history is sent monthly to the participant. The FEA forwards a record of payment history to the ICA monthly. The FEA deposits all spend-down payments received and this income offsets IRIS program funded service costs.

2.2C Spousal Impoverishment

Spousal Impoverishment refers to the way in which the resources of a married couple are counted for purposes of IRIS financial eligibility. To prevent the impoverishment of both persons the rules allow the allocation of a portion of income or assets to the community spouse. A "community spouse" is a person who is married to an IRIS participant and who is not living in a nursing home or other medical institution for 30 or more consecutive days. When both spouses are IRIS applicants/participants, each spouse may allocate resources to the other. Spousal Impoverishment rules apply to all married couples except those where the non-applicant spouse resides in a Nursing Home, ICF-MR or medical institution and has lived there for 30 or more days. (See Section 18 of the Medicaid Eligibility Handbook)

2.2C.1 Asset Allocation

The asset allocation process determines the amount of assets the married IRIS applicant may retain in order to still be considered eligible for Medicaid. The term "asset allocation" refers to the way assets may be divided between each spouse in the marital relationship for the purpose of establishing Medicaid eligibility under spousal impoverishment rules. Assets are counted on the date the applicant first requests Medicaid HCBS waiver services, or when s/he is institutionalized for 30 days or more, whichever is earlier.

Asset allocation will establish the Community Spouse Asset Share (CSAS). That is the amount of countable assets greater than the $2,000 limit that the IRIS applicant's community spouse is allowed to retain. Spousal impoverishment asset limits are adjusted annually and the maximum amount the IRIS applicant spouse may allocate varies depending on the couple's total assets. In addition, when the community spouse asset share is a court-ordered amount or set by an administrative hearing, the total amount of assets allowed may be greater than the spousal impoverishment limit. Please refer to Section 18 the Medicaid Eligibility Handbook for the most current asset allocation information or consult with the IM agency staff.

2.2C.2 Income Allocation

Income allocation occurs after the IRIS applicant is determined to be Medicaid eligible. The IM worker completes the Spousal Impoverishment Income Allocation Worksheet to determine the amount of monthly income the IRIS program applicant may allocate to his/her community spouse. Depending on the amount, the income allocation may reduce or eliminate the applicant's cost share.

After the eligibility determination, the applicant may choose to allocate all, part, or none of his/her available income to the spouse who, in turn, may choose to accept all, part, or none of the allocation. For the allocation to be applied to the cost share, the applicant must actually make the income available to his/her community spouse in a manner that can be verified. If SSI or Medicaid eligibility would be jeopardized, then the spouse may forego the allocation. If both spouses are IRIS applicants, then each may allocate income to the other.

The maximum amount of income that may be allocated to the community spouse is adjusted annually. Please refer to Section 18 of the Medicaid Eligibility Handbook or consult with the IM agency staff for more detailed information and current income allocation provisions.

2.2D Ongoing Eligibility

Once initial program eligibility has been established, all IRIS participants must complete an annual functional and financial eligibility review. Failure to maintain eligibility may result in disenrollment. Annual functional eligibility is completed by the ICA. Annual financial eligibility is completed by the IM Worker.

2.2D.1 Annual Eligibility Review

Functional eligibility redeterminations are made with the completion of a new LTC FS. The screens are conducted by qualified ICA staff in a face-to-face interview with the participant, in the place of their residence, if possible. To maintain functional eligibility, the participant must continue to receive an eligible level of care (LOC) at review.

Financial eligibility re-determinations are made with the completion of a Medicaid recertification review. The Medicaid recertification is conducted by the IM agency. To maintain financial eligibility, the participant must meet all Medicaid income and asset requirements annually at recertification. If continued financial eligibility for Medicaid is not confirmed, or continued or functional eligibility is not attained at recertification, then the participant is disenrolled (see 2.0, Enrollment).

2.2D.2 Reporting Changes

To ensure continued eligibility and accuracy in cost sharing or spend-down calculations, the participant is responsible to report any change in his/her financial status to the IM agency within ten calendar days. Failure to report changes promptly could result in a cost share overpayment or an underpayment, and may affect ongoing eligibility. Examples of the changes that must be timely reported include: any increase or reduction of medical/remedial expenses; a change in a private health plan status or premium; or an increase or decrease in income.

The IM staff will enter the report then changes in the CARES system. If the new information impacts the cost share or spend-down obligation, CARES will generate a ten day written notice informing the participant of the change, and of their right to appeal the determination.

2.2D.3 Cost Sharing and Spend-down Requirements

Important: IRIS participants who have a cost share obligation must make the monthly payment to maintain Medicaid HCBS waiver eligibility. Cost shares are collected and monitored by the FEA. The program expectation is that the cost share payment should be received by the FEA no later than the 5th of the month. The ICA provides support to the participant to ensure the cost share obligation is understood and will contact individuals when payments become delinquent. While support and assistance to understand cost share is available from the FEA and the ICA, making the cost share payment is the responsibility of the participant. Failure to meet this responsibility may result in disenrollment.

Group C eligible IRIS participants who have a spend-down must make sure they continue to meet the Medicaid spend-down requirements each month. The spend-down is comprised of those costs that the participant is responsible for each month. The spend-down is required to maintain Medicaid HCBS waiver financial eligibility. Failure to meet these requirements may result in referral for disenrollment. More information on spend-down rules and requirements are found in the Medicaid Eligibility Handbook: http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm

2.3 Nonfinancial Eligibility

The purpose of this section is to determine nonfinancial eligibility. Requirements including residency and permitted living arrangements are explained in this section.

2.3A Residency

Residency requirements are the same as the Wisconsin Medicaid rules. A person who is physically present in the state and who expresses their intent to remain in Wisconsin is a Wisconsin resident.

2.3B IRIS Program Availability

The IRIS self-directed support program is a choice available to persons residing in those counties, or regions of the state, where managed long term care programs are also operating. IRIS is not available in those counties that have not transitioned under the state's long term care reform initiative.

2.3C Community Living Arrangement

Applicants must reside in an eligible living arrangement to be eligible to participate in the IRIS program. The applicant/participant's living arrangement refers to their permanent residence. An applicant who routinely visits friends or relatives out of state does not give up their permanent residence. For example, the IRIS participant who visits a relative in Arizona for several months each winter, does not impact their state residency. Similarly, an IRIS participant who attends a college and resides on campus during the school year does not give up their permanent residence.

It should be noted that while the arrangements below are generally permitted, there are some restrictions. For example, IRIS program funds may not be used to pay for Community Based Residential Facilities (CBRFs). In addition, under most circumstances, Residential Care Apartment Complexes (RCACs) may not admit persons who have a guardian (DHS 89.29 (1)). IRIS participants and their legal representatives need to be aware of these limitations and should contact the ICA with questions regarding allowable living arrangements.

2.3C.1 Eligible Living Arrangements

Eligible living arrangements include:

2.3C.1.1 DD Target Group

Eligible living arrangements for participants with a DD include:

- A house, apartment, condominium or other private residence;
- A rooming/boarding house;
- A certified Adult Family Home (1-2 bed); and
- A licensed Adult Family Home (3-4 beds).

2.3C.1.2 PD and FE Target Group

Eligible living arrangements for persons with PD and FE include:

- A house, apartment, condominium or other private residence;
- A rooming/boarding house;
- A certified Adult Family Home (1-2 beds);
- A licensed Adult Family Home (3-4 beds); and
- A certified RCAC.

2.3C.2 Ineligible Living Arrangements

Ineligible living arrangements include:

2.3C.2.1 DD Target Group

Ineligible living arrangements for participants with a DD include:

- A hospital, Nursing Home or Institution for Mental Disease (IMD);
- An ICF-IDD or any of the state centers for people with developmental disabilities;
- A jail, prison or other correctional facility; and
- A CBRF.*

2.3C.2.2 PD and FE Target Group

Ineligible living arrangements for participants who have a PD or are FE include:

- A hospital, Nursing Home or Institution for Mental Disease (IMD);
- An ICF-IDD including any of the state centers for people with developmental disabilities;
- A jail, prison or other correctional facility; and
- A registered Residential Care Apartment Complex (RCAC); and
- A CBRF.*

*CBRF is an ineligible setting effective 12/31/14. IRIS participants already living in a CBRF have until 12/31/14 to either move to an IRIS allowable living arrangement or transfer to a program where a CBRF is an allowable living arrangement.

Note: Persons seeking enrollment in the IRIS program may be residing in one of the ineligible settings listed above at the time of application. However, final eligibility cannot be established and services through the IRIS program may not begin until the person lives in an eligible setting.

If a current IRIS participant is admitted to a Nursing Home or hospital on a short-term basis, then the short-term stays for acute care or rehabilitation will not disrupt eligibility. Admissions intending to be short-term that become long term placements may lead to program disenrollment (see 2.0, Enrollment).

2.3C.3 Temporary Living Arrangements

In transitional situations, a participant may reside in a hotel, motel, homeless shelter, or other type of transitional housing. These are permitted living arrangements. All other eligibility requirements continue to apply including Wisconsin residency and being located in a county where IRIS is available.

2.3C.4 Short Term Institutional Stays

If an IRIS participant needs to stay in an institutional setting for short-term acute care and/or rehabilitative services, then these short-term stays do not change the participant's permanent residence or living arrangement and the person retains continued eligibility for enrollment in IRIS. IRIS services however, must be suspended while the person is in this short-term setting. The participant is required to report any institutional stay to the ICA. The ICA staff may assist the person with planning and relocation activities in order for the participant to return to an eligible community living arrangement. If the temporary stay becomes permanent, then this is considered a voluntary disenrollment. An IRIS participant who has an institutional stay that lasts longer than 90 days after the admission date to the facility must be disenrolled from IRIS.

2.3C.5 Incarceration

If a participant is incarcerated in a jail, prison or other correctional facility for 30 days or more, then ICA initiates disenrollment from IRIS since this is not an eligible living arrangement.

An individual disenrolled from IRIS under any of these circumstances may be enrolled again at a future date when they no longer reside in an ineligible setting, and as long as the other eligibility requirements are met.

2.3D Need for Services

Persons who have been determined to meet the non-financial and functional eligibility criteria for waiver participation, but who do not have an assessed need for waiver services, are not eligible for Medicaid using the special IRIS program eligibility criteria (Code of Federal Regulations 42CFR 435.217(c). The Centers for Medicare and Medicaid Services defines "reasonable need" as follows: "In order for an individual to be determined to need waiver [IRIS] services, an individual must require (a) the provision of at least one HCBS waiver service, as documented in the service plan, and (b) the provision of HCBS waiver services occurs at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan."

6.0 Participant Choice of Qualified Providers

6.4 Private Duty Nursing (PDN)

Wisconsin Medicaid covers private duty nursing (PDN) for participants with medical conditions that require eight or more hours of skilled nursing in a 24-hour period. PDN is defined under Wisconsin Administrative Code § DHS107.12. PDN includes the skilled nursing services for ventilator-dependent for life support participants, as well as for participants not dependent on a ventilator. Participants with medical conditions requiring less than eight hours of skilled care in a 24-hour period are eligible for skilled nursing from a home health agency through Wisconsin Medicaid as defined under Wisconsin Administrative Code § DHS 107.11 (2a). IRIS Medicaid Waiver Participants qualifying for PDN must maximize the State Medicaid plan benefit prior to using IRIS waiver funds. Once the participant maximizes Medicaid State plan PDN services to the approved amount eligible, the participant may use IRIS waiver services, such as respite and supportive home care, for the provision of non-skilled care for those IRIS participants who are not authorized to receive 24 hours of skilled care. If an IRIS participant is eligible to use this Medicaid State plan benefit, then the participant may not opt to use IRIS funds in lieu of the Medicaid card to pay for unlicensed staff or family to provide this or similar services. The Code of Federal Regulations (CFR) §440.180 defines "Home and Community-Based Services" (including services provided by the IRIS Program) as,

> "…services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter."

Nurses in Independent Practice (NIP/PDN nurses) provide PDN services including services for recipients dependent on a ventilator for life support. The NIP/PDN delivers services to Medicaid recipients and, due to being classified as Medicaid Providers, must meet certification in order to provide Medicaid PDN services.

6.4A Private Duty Nursing and Personal Care

Even though the primary purpose for PDN does not include provision of personal care services, nursing cares remain similar to personal care. It is reasonable to assume that monitoring for any heath condition such as seizures, vital signs, or suctioning do not prohibit the NIP/PDN from performing basic nursing cares integral to the recipient's health such as care in hygiene, hydration, nutrition, dressing, grooming, mobility, toileting, transferring, keeping linens clean and dry, and other comparable tasks.

Example: If a NIP/PDN provides a bath, then the NIP/PDN is expected to clean up after the bath, just as with any other activity the NIP/PDN performs in the course of duties. The NIP/PDN would be expected to clean and maintain equipment because this activity is included in general nursing care.

6.4B Case Coordination, Forms, and Supplies

Medicaid requires the NIP/PDN, as Medicaid Providers, to maintain documentation in the participant's home. The NIP/PDN must provide documentation forms and disposable medical supplies (DMS) such as gloves. The IRIS participant is not responsible for supplying forms and DMS, nor can forms or DMS be billed to the recipient or other programs including the IRIS program. IRIS participants may not purchase forms and DMS through the IRIS plan. The Wisconsin Medicaid and BadgerCare Recipient Update from December 2002 provides additional information on these requirements.

The NIP/PDN coordinate all medical care, complete the plan of care, obtain the prior authorization, make and attend appointments, order and stock supplies, and provide this coordination under the PDN guidelines. The separate reimbursement of these activities with other funds, such as, through supportive home care (SHC) using IRIS Waiver funds because this is covered within the nursing rates and is reimbursed through the Medicaid rate.

Example: A Broker or Prior Authorization Liaison (PAL) cannot be reimbursed with IRIS funds to provide these services as it is the responsibility of the private duty nurse to provide coordination of care as part of the PDN's roles and duties as a NIP/PDN in independent practice.

6.4C Double Staffing

If a participant's condition requires double staffing, and this double assistance is medically necessary, then the double staffing may be covered by MA Card services when prior authorized. A Medicaid Personal Care (MAPC) agency supplements the PDN case and designates a "case share" between the two entities. The case share plan is reviewed and prior authorization granted by the Department of Health Services (DHS). Upon prior authorization, this is a MAPC billable card service and is therefore billed to the other provider (i.e. IRIS). IRIS Waiver funds cannot cover double staffing as this service is covered by the MA Card. Case sharing requires nurse oversight and nurse delegation. In IRIS Self-Directed Personal Care (IRIS SDPC) the nurse does not oversee or delegate responsibility to the workers.Therefore, IRIS participants are not eligible to use IRIS SDPC in a case share situation. In MAPC, the MAPC nurses directly oversee workers and may delegate responsibility and train workers to perform tasks so unlicensed workers can provide care under the direction of the MAPC nurse. An MAPC agency may supplement the PDN through a case share arrangement. The PDN and MAPC parties must follow the Nurse Practice Act requirements.

6.4D Duplication of Services

The DHS considers the request for reimbursement for services already covered under the PDN rate as "duplication of services" or double billing: Recipients have a duty not to seek the same or similar services from more than one provider [DHS 104.02 (1), Wis. Admin. Rules].

The DHS also works to ensure the best use of program resources:

- Among the reasons for prior authorization is promoting the most effective and appropriate use of available services and facilities, Wisconsin Administrative Code § DHS 107.02 (3) (b) 5; and,
- The criteria for prior authorization includes the extent to which less expensive alternative services are available, Wisconsin Administrative Code § DHS 107.02 (3) (e) 6.

6.4E Private Duty Nursing/Physician Order for Care/Staffing

The ForwardHealth Prior Authorization/Care Plan Attachment (PA/CPA) (F-11096) is a form used by the Prior Authorization nurse and the participant's physician to order or obtain a prior authorization (PA) for PDN services through Medicaid.

The nurse or physician may not order IRIS-funded services, such as SHC, through an order on the Plan of Care (PPOC) DHS form F-11096. If the physician orders up to 24 hours of "skilled nursing care," then unskilled and/or unlicensed staff cannot cover shifts ordered by a physician that a NIP/PDN must provide. Licensed nurses must provide all skilled nursing care billed through the Medicaid ForwardHealth card. Legal representatives, or family members, trained by the physician to care for a loved one, and not licensed nurses, may do so as a natural support. The IRIS program does not pay for skilled nursing tasks provided by unskilled and/or unlicensed staff as SHC, because these are not supportive home care tasks. When natural supports provide skilled care, it is not considered skilled nursing and the liability shifts from the NIP/PDN to the physician. The NIP/PDN must develop and implement a backup plan and cover shifts to maintain safety for the participant and provide continuity of care as required by Wisconsin Administrative Code § DHS 105.18(8).

If a participant experiences difficulty locating an NIP/PDN, then the participant may contract a Home Health/skilled agency to provide this type of skilled service. In cases in which the participant is unable to fill all shifts, the PA will only authorize the number of hours for which there is coverage. For example, the PPOC may order 24 hours of nursing, but the PA authorizes 16 hours of nursing because the remaining shift is not filled. The IRIS program recognizes the PPOC as the doctor's order and, therefore, IRIS funds may not support provision of skilled nursing services for uncovered PDN shifts.

An unlicensed worker such as an SHC or respite worker may never provide paid, skilled care. Because skilled care is reimbursable through the Medicaid card, it is not reimbursable through IRIS waiver funds.

If the physician determines it is safe for paid, unlicensed workers to cover shifts when nurses are not available, then only trained personal care workers with nurse oversight, such as through an MAPC agency may be considered. IRIS Self-Directed Personal Care workers are not eligible to provide this service. Combining MAPC and PDN occurs through a case share with the PDN case to provide coverage when the NIP/PDN are not available. The nurse for the MAPC agency provides the delegation and oversight to workers only for tasks that are eligible for delegation. The MAPC agency obtains its own physician orders and the PDN case coordinator or Prior Authorization Liaison (PAL) works with the agency to submit the prior authorizations to DHS for review and monitors to avoid overlaps in services (unless double staffing is approved). The system exists to ensure the NIP/PDN and the MAPC agency do not bill for the same service and to

provide continuity of care. MAPC agencies are not obligated to take on skilled cases such as those with PDN as the agency must ensure the plan is safe and meets the person's care needs.

It is possible for an IRIS participant to utilize Supportive Home Care hours while a skilled nurse is providing nursing services. The NIP/PDN maintains responsibility to ensure the participant has a clean bed and removes and replaces soiled linens with clean linens. Laundering soiled linens is not the responsibility of the NIP/PDN and, therefore, a paid, unskilled Supportive Home Care worker may launder the linens. A NIP/PDN and an unskilled worker providing SHC can provide services simultaneously because each worker provides different services. Because of the division of labor between the NIP/PDN and SHC workers, within the same task (including something such as laundry), it is permissible that both individuals work at the same time without providing a "duplication of services" as discussed in section 6D. This assumes the SHC worker never removes the soiled linens or places clean linens on the bed, and the NIP/PDN never launders the linens. If the SHC worker **did** remove and replace the linens, then duplication of services occurred, as the tasks of removing and replacing the linens are the responsibility of the NIP/PDN.

The aforementioned division of labor is not limited solely to the NIP/PDN responsibility of ensuring the participant has a clean bed; a similar division of labor exists with bathing tasks. The NIP/PDN maintains responsibility to ensure the participant is clean; therefore, provision of baths is an expected part of nursing care. Upon completion of bathing the participant, the NIP/PDN maintains the responsibility of ensuring the bathroom is clean. The NIP/PDN is not responsible to launder the towels or the participant's soiled clothing. An unskilled worker through SHC may complete this task without being considered to have engaged in duplication of services.

Unskilled workers also complete other SHC tasks including: cleaning of the home not related to the NIP/PDN nurse's tasks; certain meal preparation and meal cleanup activities; yard maintenance and/or snow removal; and, other such activities. The SHC hours documented on the approved ISSP and must comply with IRIS Work Instructions Manual Section 6.1B.2 – Caregiver Hours Assurance and Oversight. The participant and/or legal representative maintains responsibility to ensure that the SHC worker understands the job duties, including the importance of the division of tasks with the NIP/PDN to prevent duplication of services.

The IRIS Program requires participants to provide the IRIS Consultant (IC) with a copy of the PPOC to ensure the participant's IRIS ISSP adequately ensures the participant's health and safety. Refusing to provide IRIS Program staff with a copy of the PPOC may be grounds for involuntary disenrollment. See IRIS Policy Manual Chapter 7 for further information concerning disenrollment.

6.4F Health and Safety

If a participant is receiving services from a Medicaid long-term care program such as IRIS, then it is necessary for the program to ensure the health and safety of a participant. As a Medicaid provider, the NIP/PDN is held to these same standards.

IRIS participants who receive private duty nursing services must submit copies of the current F-11096 to the IRIS Consultant Agency to ensure continuity of care, and to avoid duplication of services. A copy of the PDN back-up plan and emergency procedures is also required.

6.4G Private Duty Nursing Back Up and Emergency Procedures

In accordance with Wisconsin Administrative Code § DHS 105.19 (8) and Medicaid Provider Agreement:

a) A participant's NIP/PDN shall designate an alternate NIP/PDN to provide services to the participant in the event the NIP/PDN is temporarily unable to provide services. The NIP/PDN informs the participant of the identity of the alternate NIP/PDN before the alternate nurse provides services.
b) The NIP/PDN shall document a plan for participant-specific emergency procedures in the event of a life-threatening situation, such as a fire or for severe weather warnings. The NIP/PDN makes this plan available to the participant and all caregivers prior to initiation of these procedures.
c) The NIP/PDN shall take appropriate action and immediately notifies the participant's physician, guardian, if any, and any other responsible person designated in writing by the participant or guardian of any significant accident, injury, or adverse change in the participant's condition.

The PA/PCA form, as well as the PDN back-up plan, remains in the participant's records in accordance with HIPAA regulations.[1] The NIP takes into consideration the course of action taken by the nurse, the alternate nurse, and the member's family should the back-up or emergency plan fail for any reason. If unskilled family members were part of the back-up plan, then IRIS does not reimburse for provision of these skilled services.

11.0 Appeals and Grievances

Per Wisconsin Statute § 51.61(5) (b), the Department of Health Services (DHS) oversees the implementation of the complaint, grievance, and appeals process. Contracted agencies must track and report complaints, grievances, and appeals made by participants, their representatives or providers in the IRIS program.

IRIS participants maintain the right to complain, grieve, and/or appeal any action or inaction by the IRIS program for which the participant perceives as negative. The overall system for appeals and grievances in the IRIS program offers participants various options to resolve differences. The IRIS program encourages participants to use informal procedures as a first attempt to resolve concerns, no prescribed hierarchy of procedures exist to address concerns.

In addition, 42 CFR Part 431, subpart E, and State Medicaid Manual sec. 4442.7.B, provides participants the right to a Medicaid fair hearing for certain actions.

11.1 Appeals

IRIS participants use the Medicaid State Fair Hearing process to appeal certain decisions and/or actions by the IRIS Consultant Agency (ICA) perceived by the participant as having a negative or undesirable impact. The IRIS participant submits formal appeal requests to the Division of Hearings and Appeals (DHA) within forty-five calendar days of the Notice of Action (NOA).

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[1] References:
Nurses in Independent Practice Handbook/ March 2006;
BadgerCare Plus and Medicaid Nurse in Independent Practice Online Handbook
DHS 105.19 Nurses in independent practice;
ForwardHealth Private Duty **Update** March 2010 No. 2010-15

Upon request of a State Fair Hearing, participants receive notification in the mail explaining the administrative hearing process. The process allows the participant to share evidence and to counter information used to make the decision in question. The date, time, and location of the participant's fair hearing are included in the letter. For more information, visit: http://dha.state.wi.us/home/WFS/wfsunit.htm.

Upon hearing completion, the Administrative Law Judge (ALJ) issues a decision, in writing, within ninety calendar days, summarizes the facts of the case, recites the regulation governing the case, and applies the regulation to the facts. The written decision clearly states the outcome.

In cases wherein the ICA issues a Notice of Action (NOA), the IRIS participant can file a fair hearing request with the Division of Hearings and Appeals (DHA). NOAs provide participants with an explanation regarding the basis for denial, reduction, termination, or limitation of services by the ICA.

11.1A Appeals

An appeal is a formal request to the DHA requesting a change in, or confirmation of, a decision made by an ICA or Fiscal Employer Agent (FEA) provider agency, or DHS.

Participants may appeal a decision upon receipt of an NOA, for the following situations:

- Reduced, terminated or denied requests for services;
- Denied request for payment;
- Failure to provide services or items included in a participant's support and service plan in a timely manner;
- Failure to resolve appeal or grievance in a timely manner; and
- Unacceptable support and service plan because it:
  - Requires participant to live somewhere they do not choose to live;
  - Fails to provide sufficient care, treatment or support; or
  - Requires the participant to accept care, treatment or support that is unnecessarily restrictive or unwanted.

The approved 1915(c) Medicaid Home and Community-Based Services waiver states:

> "At the time of orientation and on an annual basis, the participant receives information and education regarding the appeals and grievances processes using the document, Participant Education: Appeals and Grievances. In addition, when a Notice of Action describing the action taken and providing an explanation, additional information is sent to the participant explaining their rights and the process with regard to filing an appeal, including their opportunity to indicate on the Request for a State Fair Hearing their desire to continue their services while their appeal is under consideration. When a participant elects to continue their services and the state receives the participant's request on or before the effective date of the intended action, the services are continued automatically. When the request is not received on or before the effective date of the intended action, the participant receives written notification that their services will not be continued.
>
> Participants are informed of the right to request a fair hearing from multiple sources. The Aging and Disability Resource Center (ADRC) informs potential enrollees of their right to the fair hearing process prior to enrollment or if an enrolled IRIS participant contacts the ADRC regarding an applicable concern. ADRCs provide a brochure to all enrollees that contain this information. The county economic support unit determines financial eligibility for Medicaid and all managed long-term care programs and processes enrollments. These agencies use standardized eligibility notification forms that include information about the right to a fair hearing.

In the event a participant's request for services are denied, suspended, reduced, or terminated, the participant's IRIS Consultant Agency provides a written notice of action with an explanation of the reason for the denial. This notice is sent within 24 hours or next business day in which a decision is made. The notice of action also includes information about their right to request a Fair Hearing, how to appeal, and appeal timeframes. In this notice the person is informed that if they want to keep services in place until a decision in rendered through the Fair Hearing process, they must file their appeal within 10 days of receipt of notice. Otherwise, the timeline is 45 days to file an appeal. The IRIS participant can obtain assistance with making the request from their chosen IRIS Consultant Agency, the ADRC, the Ombudsman Program, or other person that the participant chooses.

The participant is informed of this right, in writing, within the Medicaid Fair Hearing Notification. The ICAs send this notification per the policies and procedures established by DHS. The DHS receives a copy of the notice and both DHS and the ICA maintain a record of this correspondence."

11.1B Rehearing

If the participant is not in agreement with the ALJ's decision and wishes to introduce new evidence to the case, then the participant makes a hearing request, in writing, within twenty calendar days following the ALJ's written decision.

Upon submission of this written hearing request, the DHA has thirty calendar days to determine whether there is sufficient evidence to justify a rehearing. If the DHA does not issue a written response to the rehearing request within thirty calendar days, then the request is considered denied.

11.1C Judicial Review

If the participant is not in agreement with the ALJ's decision and the ALJ denied the participant's request for a rehearing, then the participant may choose to file a petition for a Judicial Review with his or her county of residence Circuit Court within thirty calendar days of the original, denied decision.

11.2 Notice of Action

The IRIS program must provide a Notice of Action (NOA) to program participants when an "adverse action," defined as a denial, reduction, termination or limitation of previously authorized services (meaning services/goods on a participant's plan) exists or when a participant is determined financially, or functionally, ineligible for the IRIS program. The 1915(c) Medicaid HCBS Waiver states the following regarding the NOA:

"In the event a participant's request for services are denied, suspended, reduced, or terminated, the participant's IRIS Consultant Agency provides a written notice of action with an explanation of the reason for the denial. This notice is sent within 24 hours or next business day in which a decision is made. The notice of action also includes information about their right to request a Fair Hearing, how to appeal, and appeal timeframes. In this notice the person is informed that if they want to keep services in place until a decision in rendered through the Fair Hearing process, they must file their appeal within 10 days of receipt of notice. Otherwise, the timeline is 45 days to file an appeal. The IRIS participant can obtain assistance with making the request from their chosen IRIS Consultant Agency, the ADRC, the Ombudsman Program, or other person that the participant chooses.

The participant is informed of this right, in writing, within the Medicaid Fair Hearing Notification. The ICAs send this notification per the policies and procedures established by DHS. The DHS receives a copy of the notice and both DHS and the ICA maintain a record of this correspondence."

The participant must *receive* the NOA at least ten calendar days *before* the effective date of the action. If the participant decides to grieve or appeal the action, then he or she has 45 calendar days to do so. Information concerning procedures for exercising the participant's right to an appeal process accompanies the NOA.

11.2A Contents of NOA Letter

The NOA letter explanation must include the following information:

- The action the ICA provider agency has taken or intends to take including the effective date of action;
- The reason for the action, reflecting the specific reason(s) concerning the participant's situation;
- Alternative options the ICA explored with the participant prior to the decision;
- Applicable laws, regulations, statutes, or policy supporting the action;
- Procedures for exercising the participant's right to an appeal process;
- Availability of independent advocacy or ombudsman services and other local organizations able to assist the participant with the appeal process;
- The participant's ability to obtain, free of charge, copies of the IRIS record relevant to the appeal process and how to obtain copies; and,
- The participant's right to continuation of benefits pending resolution of the grievance/appeal; how to request benefits continuation; and, circumstances under which the participant may be required to re-pay the costs for these continued services.

The NOA uses easily understood language and includes a statement that written or oral interpretation is available for individuals whose native language is not English and indicates how to obtain such interpretation. The document, "IRIS Participant Appeal Rights," (P-00679) must accompany the NOA.

11.3 Complaints

DHS defines "complaint" as any element of dissatisfaction experienced by an IRIS participant, while in the IRIS program, requiring intervention that the IRIS Consultant cannot resolve. An IRIS participant may file a complaint concerning any aspect of rights, services, ICA, FEA or regarding the IRIS program in general.

IRIS participants receive annual education regarding the complaints process via the "Participant Education – Complaint and Grievances" form (F-01205F).

Receipt of complaints related to the IRIS program may come from various sources including participants, legal representatives, agency providers, participant-hired workers, family members, community members, or other interested persons on behalf of the participant. Participants make complaints verbally or in writing, during visits with the IRIS Consultant; through the IRIS Call Center; through MetaStar (the independent, third-party mediator contracted by DHS), through a Legislators' Office or the Office of the Governor.

Whenever a participant makes a complaint regarding an IRIS matter, an informal attempt to resolve the situation should occur. Typically, complaint resolution should occur, as close to the source as possible, with the appropriate ICA or FEA provider staff ensuring the complaint is properly addressed.

When participants and/or legal representatives have complaints, resolution attempts should begin with the consultant who will work to resolve the issues or concerns. If these issues or concerns involve the participant's IC, or the IC is unable to address the issues or concerns, then the participant and/or legal representative contacts the relevant agency (ICA, FEA, or Third Party Administrator) for resolution.

Agency providers with complaints should contact the appropriate ICA or FEA provider agency to address their concerns.

If the ICA or FEA is unable to resolve the problem, then the participant, legal representative, or agency provider has the right to file a grievance. The agency conducts a review of the filing.

The DHS directs complaints to the MetaStar hotline for resolution. MetaStar is contracted by DHS to resolve complaints on behalf of DHS. Participants, legal representatives, and providers should contact MetaStar via the hotline number (888-203-8338) or email address (DHSIRISGrievances@wisconsin.gov) to make a complaint.

MetaStar and the ICA and FEA provider agencies are required to document and track all complaints received, including the date of the participant complaint; a description of the complaint; the outcome of complaint resolution process, and the date of resolution or conclusion. The contracted agency must provide DHS with data and reports. The DHS reviews reports for trends and systems issues, and ensures the agency implemented the processes or relevant policy as part of the DHS' ICA and FEA agency provider monitoring and oversight.
Concerning complaints, the 1915(c) Medicaid HCBS waiver states,

> "The IRIS Consultant Agencies (ICAs) have staff who are assigned to addressing IRIS participants' concerns and grievances. Participants are notified by their chosen IRIS Consultant Agencies of these options. The ICAs also receive, respond to and track grievances and complaints from participants and providers related to IRIS, and responds to the complaint or grievance within a reasonable time period. The tracking system includes the outcome or resolution that occurs. Data on complaints and grievances is reviewed as part of contract monitoring and oversight. The ICAs, FEAs, and the agency contracted to resolve participant issues on DHS' behalf engage DHS IRIS program management and quality staff, if needed, to resolve an issue.
>
> The Fiscal Employer Agents (FEAs) also has an established system to receive, respond to and track grievances or complaints from participants and providers related to the role of the FEAs, and responds to the complaint or grievance within a reasonable time period. This includes data on the outcome of the issue. Data on complaints or grievances is reviewed as part of contract monitoring and oversight. The FEAs engage DHS IRIS program management and quality staff, if needed, to resolve an issue.
>
> If a participant is not able to resolve their complaint/grievance through their ICA's or FEA's complaint or grievance process, he or she may contact the State Medicaid Agency via a toll free hotline number and/or email address to seek resolution. Additionally, the participant may contact DHS IRIS program management and quality staff at any time to report concerns or issues. DHS staff and/or a contracted agency (MetaStar) work with the participant in an attempt to negotiate an informal resolution that is mutually agreeable to the participant and the ICA or FEAs. However, the State Medicaid agency may take contract enforcement actions through performance adjustments based on facts discovered during the information gathering part of the process. This process builds on existing quality management processes already in place and functions that DHS staff already perform in investigating complaints and working to resolve issues at the participant and systemic levels.
>
> Any of the grievance and appeal rights available to participants, including fair hearing, may be exercised at any time. While participants are encouraged to use informal procedures as a first attempt to resolve their concerns, the use of one procedure is not required, nor does it limit the opportunity to use any other procedure. In addition, participants may choose more than one avenue to resolve their issue simultaneously.

The ICAs, FEAs, MetaStar, and DHS strive to respond to complaints within 48 hours of receiving a report. Formal grievances may take up to one month to ensure a thorough investigation and establish appropriate resolution. If health or safety is at risk, each agency takes immediate action.

The participant may also contact the Ombudsmen Program directly at any time."

11.4 Grievances

A grievance is a formal complaint, based on an act, dispute, or omission concerning a participant's rights, services or with the IRIS program in general. Participants may file a grievance regarding any aspect of the IRIS experience viewed by the participant as unsatisfactory including apperception by the participant of violation or suppression of rights (see 8.0, Participant Rights and Responsibilities).
IRIS participants receive annual education regarding the grievance process via the "Participant Education – Complaint and Grievances" (F-01205F) form.

11.4A Grievance Process

Participants must submit formal grievances in writing, using the DHS Grievance – IRIS (F-01212) form. After receipt of the grievance, the agency (MetaStar, ICA, or FEA) has thirty days to review the grievance (and supporting documentation) to make a decision on necessary action or next steps. Participants, legal representatives, and providers can contact MetaStar via the hotline number (888-203-8338) or email address (DHSIRISGrievances@wisconsin.gov) to commence the grievance process.

Concerning grievances, the 1915(c) Medicaid HCBS waiver states,

"At the time of orientation and on an annual basis, the participant receives information and education regarding the appeals and grievances processes using the document, "Participant Education: Appeals and Grievances." These documents explain the complaint and grievance processes through the ICAs, FEAs, and MetaStar. These documents also explain the state fair hearing process and ombudsman program options. The IRIS Consultants (ICs) are required to meet face-to-face with the participants and explain the material in the education sheets. Additionally, these participant education sheets are available to the participants at any time on the IRIS website: http://www.dhs.wisconsin.gov/iris.

The IRIS Consultant Agencies (ICAs) have staff who are assigned to addressing IRIS participants' concerns and grievances. Participants are notified by their chosen IRIS Consultant Agencies of these options. The ICAs also receive, respond to, and track grievances and complaints from participants and providers related to IRIS, and respond to the complaint or grievance within a reasonable time period. The tracking system includes the outcome or resolution that occurs. Data on complaints and grievances is reviewed as part of contract monitoring and oversight. The ICAs, FEAs, and the agency contracted to resolve participant issues on DHS' behalf engage DHS IRIS program management and quality staff, if needed, to resolve an issue.

The Fiscal Employer Agents (FEAs) also has an established system to receive, respond to, and track grievances or complaints from participants and providers related to the role of the FEAs, and respond to the complaint or grievance within a reasonable time period. This includes data on the outcome of the issue. Data on complaints or grievances is reviewed as part of contract monitoring and oversight. The FEAs engage DHS IRIS program management and quality staff, if needed, to resolve an issue.

If a participant is not able to resolve their complaint/grievance through their ICA's or FEA's complaint or grievance process, he or she may contact the State Medicaid Agency via a toll free hotline number and/or email address to seek resolution. Additionally, the participant may contact DHS IRIS program management and quality staff at any time to report concerns or issues. DHS staff and/or a contracted agency (MetaStar) work with the participant in an attempt to negotiate an informal resolution that is mutually agreeable to the participant and the ICA or FEAs. However, the State Medicaid agency may take contract enforcement actions through performance adjustments based on facts discovered during the information gathering part of the process. This process builds on existing quality management processes already in place and functions that DHS staff already perform in investigating complaints and working to resolve issues at the participant and systemic levels.

Any of the grievance and appeal rights available to participants, including fair hearing, may be exercised at any time. While participants are encouraged to use informal procedures as a first attempt to resolve their concerns, the use of one procedure is not required, nor does it limit the opportunity to use any other procedure. In addition, participants may choose more than one avenue to resolve their issue simultaneously.

The ICAs, FEAs, MetaStar, and DHS strive to respond to complaints within 48 hours of receiving a report. Formal grievances may take up to one month to ensure a thorough investigation and establish appropriate resolution. If health or safety is at risk, each agency takes immediate action.

The participant may also contact the Ombudsmen Program directly at any time."

11.5 DHS Review

The DHS contracts with MetaStar, an external organization, to resolve participant complaints and grievances on behalf of DHS. MetaStar addresses the following issues (list not all-inclusive):

- Issues of non-payment of participant-hired workers and vendors;
- Concerns regarding budget amendments or one-time expenses;
- Concerns regarding timeliness of ICA or FEA services;
- Concerns regarding quality of ICA or FEA services; and,
- Concerns regarding unauthorized changes to the plan or wages.

11.5A DHS Review Process

Participants, legal representatives, and providers can contact MetaStar via the hotline number (888-203-8338) or email address (DHSIRISGrievances@wisconsin.gov) to commence the DHS review request process.

The 1915(c) Medicaid HCBS waiver states,

"The Department of Health Services is the State Agency responsible for the operation of the grievance or complaint system. Initial resolution is delegated to the IRIS Consultant Agencies and the Fiscal Employer Agents. If these agencies are unable to resolve an issue, or the participant chooses to contact DHS directly, then DHS takes on management of the grievance or complaint through the use of a contracted agency (MetaStar)."